Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PO BOX 700311
SAN ANTONIO TX 78270-0311

COMBINED CHIROPRACTIC SERVICES &
REHABILITATION, INC.

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2963-01

MFDR Date Received

MAY 3, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review bills that we resubmitted to you for Reconsideration. Included you will find all HICFs' and pre-authorization for the EMG_NCV and proper documentation along with Dr Jackie Stephenson MD note for the patient…to Dr. Douglas W. Burke, and he referred [Claimant] to Dr. Cary Davis, DC to perform the Lower and Upper EMG-NCV test. DR. Cary Davis, DC is a licensed practitioner to perform this test in the Worker Compensation System in the State of Texas. We have established medical necessity by his treating doctor Douglas W. Burke DC."

Amount in Dispute: $2395.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual notes that even though the invalid letter indicates a certified quantity of 1, the paragraph immediately following states:

> Per Physician Advisor, nonauthorization given for ODG EMG/NCV BLE w/ Anal Sphineter / Chem 12, testosterone, thyroid prolactin . Requestor has been instructed in reconsideration, and/or the final option after reconsideration, DWC MDR process. If you are requesting IRO review of this adverse determination, please complete the TDI form LHL009…"

I spoke with the requestor's contact, Michelle Mccumber, on May 17, 2011. Ms. Mccumber stated that she has a copy of the preauthorization denial letter dated October 29, 2010 (Attachment C) in her file…Texas Mutual notes that while the requestor has the denial letter, it did not include the denial letter in its DWC-60 packet."

Response Submitted by: Texas Mutual Insurance Co., 6210 East Hwy. 290, Austin, TX 78723-1098

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2010	CPT Code 95900-59 (6) - Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study	$690.00	$0.00
	CPT Code 95903-59 (4) - Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study	$460.00	$0.00
	CPT Code 95904-59 (6) - Nerve conduction, amplitude and latency/velocity study, each nerve;	$690.00	$0.00

	sensory		
	CPT Code 95934-59 (2) - H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle	$230.00	$0.00
	CPT Code 95861 - Needle electromyography; 2 extremities with or without related paraspinal areas	$250.00	$0.00
	HCPCS Code A4556 (6) - Electrodes (e.g., apnea monitor), per pair	$30.00	$0.00
	HCPCS Code A4215 - Needle, sterile, any size, each	$5.00	$0.00
	HCPCS Code A4558 - Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz	$5.00	$0.00
	CPT Code 99211-25 - Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	$35.00	$0.00
TOTAL		$2395.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services
4. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the procedure for submitting medical bills.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 16, 2011
   - CAC-W1-Workers' compensation state fee schedule adjustment.
   - CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised or either the remittance advice remark code or NCPDP reject reason code).
   - CAC-39-Services denied at the time authorization/pre-certification was requested.
   - CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 275-The health care provider requested preauthorization, however, the insurance carrier denied approval (according to Chapter 134).
   - 732-Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed.
   - 751-Multiple HCP services on same bill, DWC rules 133.10 & 133.20(E)(2) require the name of the licensed HCP rendering treatment in box # 31.
   - 857-Modifier-25 billed. Documentation does not support a significant, separately identifiable E&M service.

Explanation of benefits dated March 24, 2011

- CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised or either the remittance advice remark code or NCPDP reject reason code).
- CAC-18-Duplicate claim/service.
- CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 224-Duplicate charge.
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 857-Modifier-25 billed. Documentation does not support a significant, separately identifiable E&M service.

Issues

1. Does a preauthorization issue exist in this dispute?
2. Are HCPCS codes A4556, A4215 and A4558 included in another service/procedure billed on December 17, 2010?
3. Does the documentation support a separate identifiable Evaluation and Management service? Is the requestor entitled to reimbursement for CPT code 99211-25?

Findings

1. The respondent denied reimbursement for the disputed services, CPT codes 95900, 95903, 95904, and 95861, based upon reason code "275-The health care provider requested preauthorization, however, the insurance carrier denied approval (according to Chapter 134)."

   28 Texas Administrative Code § 134.600(p)(12) states "Non-emergency health care requiring preauthorization includes: treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

   The October 29, 2010 preauthorization report indicates under the heading "Utilization Review Decision: Per Physician Advisor, nonauthorization given for ODG EMG/NCV BLE w/Anal Sphineter / Chem 12, testosterone, thyroid prolactin…"

   Therefore, the disputed services billed under CPT codes 95900, 95903, 95904, 95861 and 95934 were not preauthorized and reimbursement is not recommended.

2. The respondent denied reimbursement for HCPCS codes A4556, A4215 and A4558 based upon reason codes "CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated"; and "217-The value of this procedure is included in the value of another procedure performed on this date".

   Per Medicare rules HCPCS codes A4556 and A4558 are bundled codes and payment allowance is included in another service; therefore, reimbursement is not recommended.

   Per Medicare rules HCPCS code A4215 is not covered by Medicare in any payment system; therefore, reimbursement is not recommended.

3. According to the explanation of benefits the respondent denied reimbursement for the office visit, CPT code 99211, based upon reason codes "CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised or either the remittance advice remark code or NCPDP reject reason code"; "225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information", and "CAC-W1-Workers' compensation state fee schedule adjustment".

   Dr. Davis appended modifier 25 to code 99211 to identify a significant, separate evaluation and management service.

   Modifier 25 is defined as "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the

same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service."

A review of the submitted documentation finds that Dr. Davis did not submit a copy of the office visit report to support billing of CPT code 99211-25; therefore, the documentation does not support a significant, separate evaluation and management service. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		7/12/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.